STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner

v **File No. 122810-001**

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _19th___ day of December 2011
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On August 10, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*. The Commissioner reviewed the request and accepted it on August 17, 2011. The Petitioner receives health care benefits through a group plan sponsored by her husband's employer. The plan is underwritten by Blue Cross Blue Shield of Michigan (BCBSM).

The issue in this external review can be decided by a contractual analysis. The contract here is BCBSM's *Community Blue Group Benefits Certificate* (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner resides in XXXXX, XXXXX. On September 16, 2010, the Petitioner had surgery to repair her knee. The surgery was performed by Dr. XXXXX, a XXXXX orthopedic surgeon. Dr. XXXX does not participate with BCBSM or any other Blue Cross Blue Shield plan. Dr. XXXXX charged $22,225.00 for the surgery. BCBSM paid $3,344.50.

The Petitioner, believing BCBSM's payment to be inadequate, appealed the amount paid through BCBSM's internal grievance process. BCBSM held a managerial-level conference on May 4, 2011, and issued a final adverse determination dated June 14, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's surgery?

IV. ANALYSIS

Petitioner's Argument

The Petitioner believes that the amount paid for her surgery is unacceptable. She understands that her doctor is out of network but it was her understanding through phone conversations with representatives of BCBSM that BCBSM would cover a greater percentage of the charges. In addition, she states her surgeon believes that the submitted fees for her surgery were reasonable and customary for the procedure in the XXXXX region.

The Petitioner believes BCBSM should be required to pay substantially more for her surgery.

BCBSM's Argument

BCBSM points out that the certificate (p. 4.2) provides that BCBSM's payment is based on an "approved amount" for a covered service. "Approved amount" is defined on p. 7.2 of the certificate as "[t]he lower of the billed charge or [BCBSM's] maximum payment level for the covered service. . . ."

To determine its maximum payment level for each service, BCBSM applies the resource based relative value screen scale (RBRVS). This is a reimbursement structure developed by physicians which reflects the resources required to perform each service, including physician time, specialty training, malpractice premiums, and practice overhead. BCBSM regularly reviews the ranking of procedures to address the effects of changing technology, training and medical practice. Using RBRVS, BCBSM determined that its maximum payment level for the September 16, 2010, surgery was $3,344.50. There is nothing in the certificate that requires BCBSM to pay any more than the approved amount. BCBSM argues that the amount it paid for the Petitioner's surgery was correct and in accordance with the terms of the certificate.

Commissioner's Review

Under the terms of the certificate, the Petitioner incurs the least out-of-pocket cost if she receives services from providers who participate with BCBSM (or with a Blue Cross or Blue Shield plan in another state). Participating providers have entered into an agreement with BCBSM to accept the approved amount as payment in full for covered services provided to BCBSM enrollees. However, nonparticipating providers have no contractual obligation to accept the approved amount as payment in full and may bill a BCBSM member for any balance over BCBSM's approved amount. The certificate (page 4.33) explains the possible consequences when services are received from nonparticipating providers:

> If the nonpanel provider is **nonparticipating**, you will need to pay most of the charges yourself. Your bill could be substantial. . . .
>
> **NOTE:** Because nonparticipating providers often charge more than our maximum payment level, our payment to you may be less than the amount charged by the provider.

BCBSM pays the same approved amount to both participating and nonparticipating providers. BCBSM paid its maximum payment level (and thus its approved amount) for the September 16, 2010, surgery. The certificate does not require a nonparticipating provider to be paid a greater amount than a participating provider. Moreover, as a nonparticipating provider, Dr. XXXXX is not bound to accept BCBSM's approved amount as payment in full and he may bill the Petitioner for any difference between his charge and BCBSM's approved amount.

The Petitioner stated that she felt a BCBSM representative had led her to believe that BCBSM's payment would be higher than what was actually paid. Under PRIRA, the Commissioner's role is limited to determining whether BCBSM has properly administered health care benefits under applicable statutes and the terms of the health plan's policy or certificate of coverage. Resolution of the factual dispute described by the Petitioner (what was said or not said during a telephone conversation) cannot be a part of this review because the PRIRA process lacks the hearing procedures necessary to make findings of fact based on evidence such as oral statements.

After reviewing the record, the Commissioner finds that BCBSM covered the Petitioner's September 16, 2010, surgery correctly under the terms and conditions of the certificate.

V. ORDER

Blue Cross Blue Shield of Michigan's final adverse determination of June 14, 2011, is upheld. BCBSM is not required to pay any additional amount for the Petitioner's surgery of September 16, 2010.

This is a final decision of an administrative agency. Under MCL 550.1915(1), any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner